MI FluFocus

Influenza Surveillance and Avian Influenza Update

Bureau of Epidemiology
Bureau of Laboratories

Michigan Department of Community Health
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New updates in this issue:

- **Michigan:** RSV activity continues to rise; emergency department respiratory complaints also rise.
- **National:** CDC releases latest estimates of 2009 H1N1 cases, hospitalizations and deaths.
- **International:** WHO announces 2010-11 vaccine strains; Egypt and Indonesia report H5N1 cases.

****2009 Influenza A (H1N1) virus Updates****

Please continue to reference the MDCH influenza website at www.michigan.gov/flu for additional 2009 H1N1 information. Local health departments can find guidance documents in the MI-HAN document library. In addition, additional laboratory-specific information is located at the Bureau of Laboratories H1N1 page at http://www.michigan.gov/mdch/0,1607,7-132-2945_5103-213906--,00.html.

****Influenza Surveillance Reports****

Michigan Disease Surveillance System: The week ending February 13th showed aggregate influenza, individual influenza, and 2009 novel influenza cases slightly decreased from the previous week's levels. All influenza categories, especially individual cases, are lower than the levels seen at this time last year.

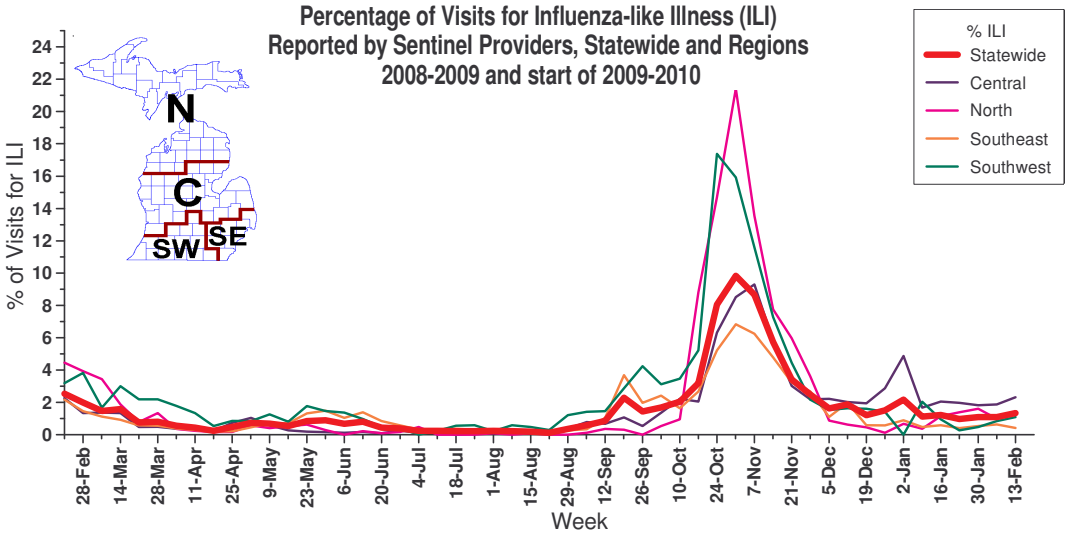
During February 7-13, 2010, 8730 cases of flu-like illness and confirmed and probable cases of seasonal and novel influenza were reported in Michigan. 2106 hospitalizations and 79 deaths associated with influenza were reported during this time. This report is updated every Tuesday by 5:00 pm and can be accessed at "Current H1N1 Activity" on this website: http://www.michigan.gov/h1n1flu.

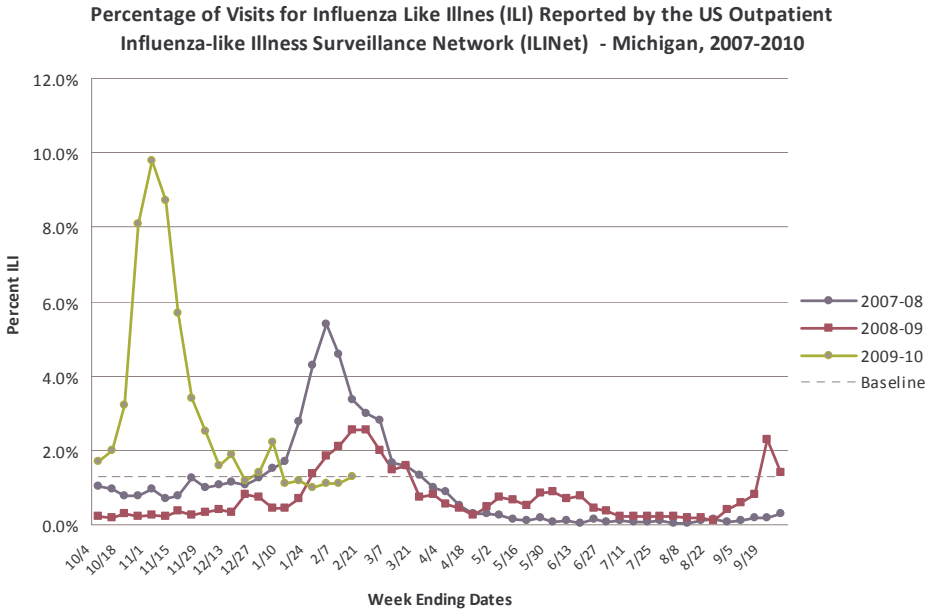
Emergency Department Surveillance: Emergency department visits from constitutional complaints remained steady near the previous week's levels, while respiratory complaints increased slightly. Constitutional complaints are slightly lower than levels from this time last year. Although respiratory complaints have increased steadily over the past few weeks, they are comparable to what was seen at this time last year. In the past week, there were six constitutional alerts in the C(4), N(1), and SW (1) Influenza Surveillance Regions, and three respiratory alerts in the C(2) and N(1) Regions.

Over-the-Counter Product Surveillance: Chest rub and cough/cold sales held steady near previous week's levels, while children's electrolytes and thermometers decreased slightly towards the end of the week. Over the past month, chest rub and electrolyte sales have steadily increased. All indicators are in line with sales seen at the same time last year, except for chest rubs, which are slightly higher.

Sentinel Provider Surveillance (as of February 18): During the week ending February 13, 2010, the proportion of visits due to influenza-like illness (ILI) remained low levels but slightly increased to 1.3% overall; 120 patient visits due to ILI were reported out of 9,041 office visits. Thirty-one sentinel sites provided data for this report. Activity increased in three surveillance regions: Southwest (1.1%), North (1.4%) and Central (2.3%) and decreased in the Southeast (0.4%) region. Of the 120 patients with ILI, 23 (19%) were 0-4 years old, 54 (45%) were 5-24 years old, 26 (22%) were 25-49 years old, 8 (7%) were 50-64 years old and 9 (8%) were 65 or older; however, 12 (39%) of the 31 reporting sites were either Student Health Centers or Pediatricians. Please note that rates may change as additional reports are received.

As part of pandemic influenza surveillance, CDC and MDCH highly encourage year-round participation from all sentinel providers. New practices are encouraged to join the sentinel surveillance program today! Contact Cristi Carlton at 517-335-9104 or CarltonC2@michigan.gov for more information.





Laboratory Surveillance (as of February 13): During February 7-13, MDCH Bureau of Laboratories identified one 2009 Influenza A (H1N1) isolate. For the 2009-2010 season (starting on October 4, 2009), MDCH BOL has identified 605 influenza isolates:

- 2009 Influenza A (H1N1): 604
- Influenza B: 1

11 sentinel labs reported for the week ending February 13, 2010. 4 labs reported sporadic influenza A activity (SE, C, N); 7 labs had no influenza A positives (SE, SW, C). 1 lab reported sporadic influenza B activity (N). 7 labs reported low or increasing RSV positives (SE, SW, C, N), 2 labs had moderately elevated RSV positives (SE, C), and 1 lab reported highly elevated numbers of RSV positives (SE, SW)

Michigan Influenza Antigenic Characterization (as of February 18): One 2009 H1N1 influenza A virus from Michigan has undergone further characterization at the CDC. This virus was characterized as A/California/07/2009 (H1N1)-like, which is the recommended strain for the H1 component of the 2010-11 Northern Hemisphere vaccine.

Michigan Influenza Antiviral Resistance Data (as of February 18): Results are currently not available for antiviral resistance at CDC for the 2009-2010 season.

Antiviral resistance testing takes months to complete and cannot be used to guide individual patient treatment. However, CDC has made recommendations regarding the use of antivirals for treatment and prophylaxis of influenza. The guidance is available at http://www.cdc.gov/H1N1flu/recommendations.htm.

Influenza-Associated Pediatric Mortality (as of February 18): Five 2009 H1N1 influenza-associated pediatric mortalities (SE(3), SW, N) have been reported to MDCH for the 2009-2010 influenza season.

***CDC has asked states for information on any pediatric death associated with influenza. This includes not only any pediatric death (<18 years) resulting from a compatible illness with laboratory confirmation of influenza, but also any unexplained pediatric death with evidence of an infectious process. Please immediately call MDCH to ensure proper specimens are obtained. View the complete MDCH protocol online at http://www.michigan.gov/documents/mdch/ME_pediatric_influenza_guidance_v2_214270_7.pdf.

Influenza Congregate Settings Outbreaks (as of February 18): Seven congregate setting outbreaks with confirmatory novel influenza A H1N1 testing (2SE, 3 SW, 1C, 1N), and two outbreaks associated with positive influenza A tests (1C, 1N) have been reported to MDCH for the 2009-2010 influenza season. These are 8 school facilities and 1 long term care facility.

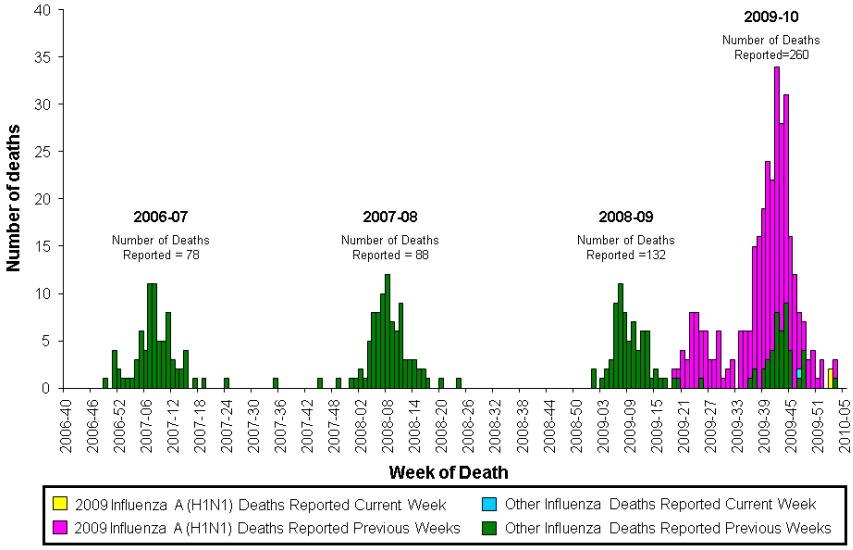
During fall 2009, 567 influenza-related school and/or district closures in Michigan (Public Health Preparedness Region 1 - 55, Region 2N - 4, Region 2S – 8, Region 3 - 54, Region 5 - 153, Region 6 - 100, Region 7 - 109, Region 8 - 84) were reported.

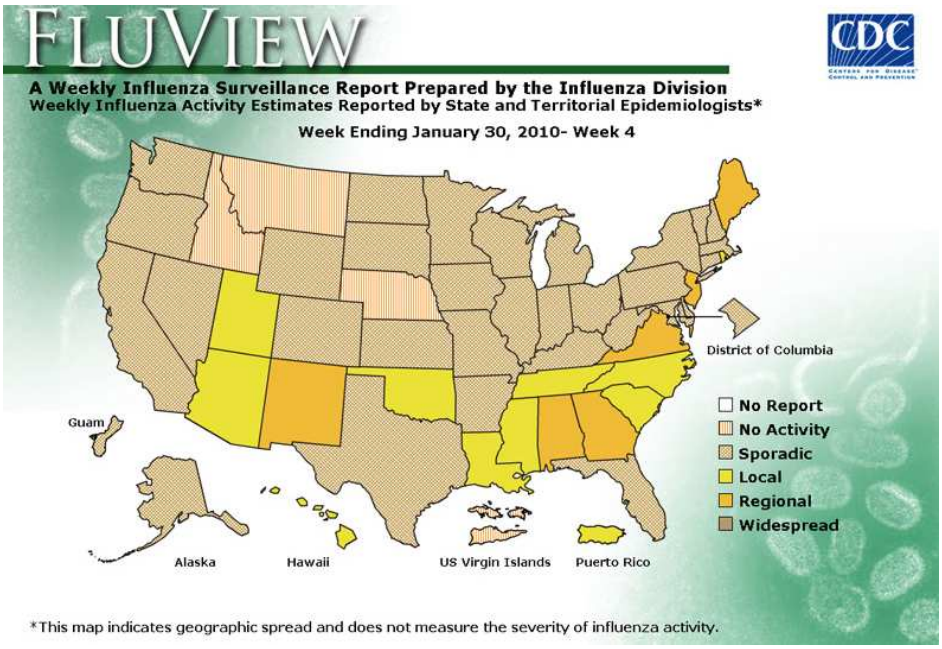
National (CDC [edited], February 12): During week 5 (Jan 31-Feb 6, 2010), influenza activity remained at approximately the same levels as last week in the U.S. 206 (4.8%) specimens tested by U.S. World Health Organization and National Respiratory and Enteric Virus Surveillance System collaborating laboratories and reported to CDC/Influenza Division were positive for influenza. All subtyped influenza A viruses reported to CDC were 2009 influenza A (H1N1) viruses. The proportion of deaths attributed to pneumonia and influenza (P&I) was below the epidemic threshold. Three influenza-associated pediatric deaths were reported. Two deaths were associated with 2009 influenza A (H1N1) virus infection and one was associated with an influenza A virus for which the subtype was undetermined. The proportion of outpatient visits for influenza-like illness (ILI) was 2.1% which is below the national baseline of 2.3%. Three of 10 regions (Regions 4, 7, and 9) reported ILI above region-specific baseline levels. No states reported widespread influenza activity, six states reported regional influenza activity, Puerto Rico and 11 states reported local influenza activity, the District of Columbia, Guam, and 28 states reported sporadic activity, four states reported no influenza activity, and the U.S. Virgin Islands and one state did not report.

Since August 30, 2009, CDC has received 260 reports of influenza-associated pediatric deaths that occurred during the current influenza season (47 deaths in children less than 2 years old, 28 deaths in children 2-4 years old, 97 deaths in children 5-11 years old, and 88 deaths in children 12-17 years old). Two hundred fourteen (82%) of the 260 deaths were due to 2009 influenza A (H1N1) virus infections, 45 were associated with an influenza A virus for which the subtype is undetermined, and one was associated with an influenza B virus infection. A total of 274 deaths in children associated with 2009 influenza A (H1N1) virus infection have been reported to CDC.

Among the 260 deaths in children, 135 children had specimens collected for bacterial culture from normally sterile sites and 43 (31.9%) of the 135 were positive; *Streptococcus pneumoniae* was identified in 11 (25.6%) of the 43 children and *Staphylococcus aureus* was identified in 13 (30.2%) of the 43 children. Three *S. aureus isolates* were sensitive to methicillin, nine were methicillin resistant, and one did not have sensitivity testing performed. Twenty-nine (67.4%) of the 43 children with bacterial coinfections were five years of age or older, and 16 (37.2%) of the 43 children were 12 years of age or older.

Number of Influenza-Associated Pediatric Deaths by Week of Death: 2006-07 season to present





To access the entire CDC weekly surveillance report, visit http://www.cdc.gov/flu/weekly/fluactivity.htm

From http://www.cdc.gov/h1n1flu/updates/us/#totalcases:

U.S. Influenza and Pneumonia-Associated Hospitalizations and Deaths from Aug 30, 2009–Feb 6, 2010

Cases Defined by	Hospitalizations	Deaths
Influenza Laboratory-Tests**	40,030	1,937

**States report weekly to CDC either 1) laboratory-confirmed influenza hospitalizations and deaths or 2) pneumonia and influenza syndrome-based cases of hospitalization and death resulting from all types or subtypes of influenza. Although only the laboratory confirmed cases are included in this report, CDC continues to analyze data both from laboratory confirmed and syndromic hospitalizations and deaths.

National (CDC, February 12): CDC Estimates of 2009 H1N1 Influenza Cases, Hospitalizations and Deaths in the United States, April 2009 – January 16, 2010; available online at http://www.cdc.gov/h1n1flu/estimates_2009_h1n1.htm.

CDC estimates that between 41 million and 84 million cases of 2009 H1N1 occurred between April 2009 and January 16, 2010. The mid-level in this range is about 57 million people infected with 2009 H1N1. CDC estimates that between about 183,000 and 378,000 H1N1-related hospitalizations occurred between April 2009 and January 16, 2010. The mid-level in this range is about 257,000 2009 H1N1-related hospitalizations. CDC estimates that between about 8,330 and 17,160 2009 H1N1-related deaths occurred between April 2009 and January 16, 2010. The mid-level in this range is about 11,690 2009 H1N1-related deaths.

International (WHO [edited], February 18): It is recommended that the following viruses be used for influenza vaccines in the 2010-2011 influenza season (northern hemisphere):

— an A/California/7/2009 (H1N1)-like virus [current pandemic strain, changed from 2009-2010 vaccine];
— an A/Perth/16/2009 (H3N2)-like virus [changed from 2009-2010 vaccine];*
— a B/Brisbane/60/2008-like virus [same as 2009-2010 vaccine]

* A/Wisconsin/15/2009 is an A/Perth/16/2009 (H3N2)-like virus and is a 2010 southern hemisphere vaccine virus.

International (WHO Pandemic Update 87 [edited], February 12): As of 7 February 2010, worldwide more than 212 countries and overseas territories or communities have reported laboratory confirmed cases of pandemic influenza H1N1 2009, including at least 15292 deaths.

In the temperate zone of the northern hemisphere, overall pandemic influenza activity continued to decline in most countries. The most active areas of transmission continue to be in later peaking areas, particularly northern Africa, South Asia, and East Asia. Of note, Senegal became the third country within

the past month (and fifth overall) to confirm first cases of pandemic H1N1 2009 in West Africa. There is insufficient evidence at this point to determine if this heralds the beginning of a period of more widespread transmission in West Africa, which heretofore may have been largely spared a significant period of communitywide pandemic influenza virus transmission. In North Africa, pandemic influenza transmission persists but substantial declines in activity have been observed over the past month across the region. In Morocco, levels of ILI have returned to near baseline, and in Egypt, the number of confirmed cases has declined considerably. In Sub-Saharan Africa, limited data suggest that pandemic influenza virus transmission may be geographically localized in most countries reporting surveillance data to WHO, and the overall intensity of activity may be low.

In South and Southeast Asia, pandemic influenza virus continues to circulate widely across the region, however, overall activity continues to decrease or remain low in most places. In India, influenza transmission persist, particularly in western, and to a lesser extent, in northern India, however, overall the numbers of cases have declined substantially. In Thailand, overall activity remains low and unchanged since the previous reporting period, however, focal areas of increased ILI activity were reported in central and northern Thailand.

In East Asia, pandemic influenza transmission persists across the region; however, overall activity has declined substantially in most places. In China, pandemic and seasonal influenza viruses continue to co-circulate, however, over the last several weeks, seasonal influenza type B viruses have been predominant. In Japan, influenza activity continues to decrease towards seasonal baselines, including in Okinawa which is experiencing greater levels of influenza activity than in other parts of the country. In Republic of Korea (S. Korea), levels of ILI have decreased substantially to near baseline levels.

In Europe, although pandemic influenza virus continues to circulate widely, particularly across central, southern, and eastern Europe, the overall intensity of pandemic influenza activity has declined substantially from peaks of activity seen earlier during the winter transmission period. Among 15 countries testing more than 20 sentinel respiratory samples, the proportion of samples testing positive for influenza ranged from 0-14%. Recent slight increases in rates of ARI in Slovakia, Slovenia, and the Russian federation, do not appear to be associated with detections of influenza viruses and may be due to other circulating respiratory viruses.

In the Americas, both in the tropical and northern temperate zones, overall pandemic influenza activity continued to decline or remain low in most places. In Central America and Caribbean, pandemic influenza virus transmission persists but overall activity remains low or unchanged in most places. A high intensity of respiratory diseases with increasing trend was reported in Guatemala, however, the increased activity does not appear to be associated with increased detections of influenza viruses and may be due to other circulating respiratory viruses.

In temperate regions of the southern hemisphere, sporadic cases of pandemic influenza continued to be reported without evidence of sustained community transmission. Pandemic influenza (H1N1) 2009 virus continues to be the predominant influenza virus circulating worldwide. In addition to the increasing proportion of seasonal influenza type B viruses recently detected in China, low levels of seasonal H3N2 and type B viruses are circulating in parts of Africa, East and Southeast Asia and are being detected only sporadically on other continents.

MDCH reported **SPORADIC INFLUENZA ACTIVITY** to the CDC for the week ending February 13, 2010.

For those interested in additional influenza vaccination and education information, the MDCH *FluBytes* is available at http://www.michigan.gov/mdch/0,1607,7-132-2940_2955_22779_40563-125027--,00.html.

Avian and Novel Influenza Activity

WHO Pandemic Phase: Phase 6 – characterized by increased and sustained transmission in the general population. Human to human transmission of an animal or human-animal influenza reassortant virus has caused sustained community level outbreaks in at least two WHO regions.

National, Laboratory Surveillance (*Pediatrics* 2010;125:e645–e650 [abstract], February 15):
OBJECTIVE: To evaluate the performance of a rapid influenza diagnostic test (RIDT) in detecting H1N1 2009 influenza A virus in respiratory samples from pediatric patients in comparison to that of real-time reverse-transcriptase polymerase chain reaction (rRT-PCR) and viral culture.

METHODOLOGY: This was a cross-sectional diagnostic-accuracy study conducted at a tertiary care children's hospital. Patients for whom the RIDT (BinaxNOW [Binax, Inc, Portland, ME]), viral culture, and rRT-PCR results were known were included. Sensitivity, specificity, and likelihood ratios (LRs) were calculated.

RESULTS: A total of 3030 specimens had RIDT results paired with both rRT-PCR and viral culture results. With rRT-PCR as the reference, overall test sensitivity was 45% (95% confidence interval [CI]: 43.3%– 46.3%) and specificity was 98.6% (95% CI: 98.1%–99%). Positive and negative LRs were 32.9 (95% CI: 22.9–45.4) and 0.56 (95% CI: 0.54–0.58), respectively. RIDT sensitivity was significantly higher in young infants and children younger than 2 years than in older children. Using viral culture as the reference standard, RIDT sensitivity was 55.5% (95% CI: 51.9%–95.6%) and specificity was 95.6% (95% CI: 95%–96.1%). The positive and negative LRs were 12.6 and 0.47, respectively.

CONCLUSIONS: The RIDT had relatively poor sensitivity but excellent specificity in this consecutive series of respiratory specimens obtained from pediatric patients. Although a positive RIDT result was highly accurate in predicting infection with influenza type A H1N1 2009 in children, a negative RIDT result did not preclude a child having H1N1. Therefore, for children at high risk with influenza-like illnesses during high-prevalence periods of influenza, empiric initiation of antiviral therapy should be considered for patients with a negative RIDT result.

International, Human (WHO, February 12): The Ministry of Health of Indonesia has announced a new case of human infection of H5N1 avian influenza. A 25-year-old female from South Jakarta District, DKI Jakarta Province died on 25 January 2010. Laboratory tests were positive for H5N1 virus infection. The case was possibly infected from direct contact with poultry.

Of the 163 cases confirmed to date in Indonesia, 135 have been fatal.

International, Human (WHO, February 17): The Ministry of Health of Egypt has announced two new cases of human H5N1 avian influenza infection.

The first case is a 32 year-old male from Ashmon district in Menofya Governorate. He developed symptoms on 6 February and was hospitalized on 8 February, where he received oseltamivir treatment. He is in a stable condition.

The second case is a 29 year-old pregnant female from Elsadat District, Menofya Governorate. She developed symptoms on 6 February and was hospitalized on 12 February, where she received oseltamivir treatment. She died on 13 February.

Investigations into the source of infection indicated that both cases had exposure to sick and dead poultry. The cases were confirmed by the Egyptian Central Public Health Laboratories, a National Influenza Center of the WHO Global Influenza Surveillance Network (GISN).

Egyptian authorities have also reported that 2 deaths have occurred in the previously announced cases; the 37 year-old male from Helwan District, Helwan Governorate who developed symptoms on 31 January and the 29 year-old female from Elsadat District, Menofya Governorate who developed symptoms on 27 January .

Of the 99 laboratory confirmed cases of avian influenza A(H5N1) reported in Egypt, 30 have been fatal.

International, Human (The Canadian Press [edited], February 11): H1N1 influenza landed a higher proportion of Canadians in ICUs and on ventilators, and at a much younger age on average, than seasonal flu does in a typical year, says a report assessing the comparative impact of the pandemic virus.

The study by the Canadian Institute for Health Information compared hospitalization statistics for H1N1 patients between April and December to data for patients with regular flu during the 2007-2008 season.

"Initially there were clinical perceptions of the patients: they seemed younger, they seemed sicker," co-author Kathleen Morris said of the H1N1 pandemic that began last April.

“What this does is take a look at all of the H1N1 patients that were hospitalized in Canada and compare them to a full hospitalization (seasonal) flu year, so right across the country,” Morris, head of emerging issues at CIHI, said Thursday from Ottawa.

“So it gives us a clearer sense of A, whether those findings are confirmed by the data, and B, what magnitude is the difference.”

She said researchers were surprised at how big some of the differences were.

“People admitted to hospital with H1N1 were younger than what we'd come to expect in a typical flu year, and those who died were younger, too,” said Morris.

The median age for patients hospitalized with H1N1 was 28, compared to 71 for people admitted for seasonal influenza or flu-related pneumonia. Among those sent to the ICU, the median age of H1N1 patients was the mid-40s, while seasonal flu patients in a typical year had a median age of 68.

There was a staggering difference in the median ages of those who died: the mid-50s for H1N1 and the mid-80s for those from complications of seasonal flu, the most common of which is pneumonia.

“So that's something about the patient that seems to be a bit different,'' Morris said. ``There's also something about the kinds of care they needed in hospital that seemed to be different.”

The researchers found that a higher proportion of patients in hospital for H1N1 were admitted to an intensive care unit _ almost one in six compared with about one in 10 of those with seasonal flu or flu-related pneumonia.

And when it came to the proportion of patients who needed a ventilator to assist breathing, H1N1 patients were more than twice as likely to require the machines.

“We also know that H1N1 appears to have had a greater impact on some subgroups of the population _ like pregnant women _ than what we'd expected in a typical year,” Morris said.

The study found the proportion of pregnant women hospitalized with H1N1 was higher than what would be expected in a typical flu year _ 21 per cent versus 13 per cent.

Four of the pregnant women with H1N1 died, she said. “And when we looked in all of 2007-8, there were no deaths among women hospitalized with flu or pneumonia.”

Commenting on the study, Dr. Michael Gardam said that while there are no big surprises in the report, it provides another perspective using a different set of data.

“Most people with it did have mild disease, but it really points out that actually there were a substantial number of people who were quite sick who ended up ventilated,” said Gardam, head of infection prevention and control for Toronto's University Health Network.

“It just reinforces how lucky we were, that had this virus had a little bit more of the right stuff, we could have been in really big trouble.”

Gardam believes we've seen the end of the H1N1 influenza pandemic because such a high proportion of Canadians has either been infected with the virus or been vaccinated against it.

“It becomes very difficult for the virus to take off ... You're still going to get cases, but you're not going to get those big peaks like we had in the first and second wave because there simply is not enough fuel.”

Morris said that while the CIHI study answers a lot of questions about what happened with H1N1, more research is needed to answer the why questions, as in “Why did it behave the way it did?”

“We hope that it's a good springboard for more study, because there's still a lot that's not known about H1N1.”

International, Hand Sanitizer (Winnepeg Free Press, February 16): It's an unintended consequence of the fight against germs during the recent outbreak of the H1NI virus.

Police and social advocates say addicts are abusing hand sanitizer after the product flooded onto store shelves and into dispensers in most public buildings last year.

Sgt. Darrall Randy Kotchon, a Winnipeg police officer who works in a community support unit, said his officers have received reports that addicts are consuming the gel and have found a lot of discarded bottles of the stuff.

Experts say people are adding salt to the sanitizer, which separates pure alcohol from the product with potentially dangerous results.

At one of the city's main shelters workers have confiscated sanitizer bottles and stopped leaving salt out on tables so people have to ask to use it.

"It's similar to individuals who are using sniff, or they're using mouthwash, or they're using hairspray," said Kotchon.

Reports of hand sanitizer abuse began last year, said police, when officers encountered the issue on patrol and from reports by residents.

Business owners need to be particularly vigilant, he said. "What unfortunately has happened is people are realizing this is something they can use to get drunk and intoxicated on," Kotchon said.

Brian Bechtel, executive director of Main Street Project, a city homeless shelter, said staff confiscated four jugs of sanitizer this week alone. Some clients steal sanitizer from public places, he said, though staff members are now seizing more consumer bottles.

"It seems like it's almost daily now," said Bechtel.

Staff decided to use non-alcoholic sanitizer at the shelter to discourage misuse.

A Senate committee heard last June that federal health officials discussed whether to send hand sanitizer to some remote First Nations battling the H1N1 flu.

An official said alcohol in the sanitizer was a concern.

Kotchon said no charges have been laid against shop owners for selling the hand sanitizers to addicts.

Heidi Graham, a Winnipeg Regional Health Authority spokeswoman, said dispensers are locked to stop people from stealing the liquid.

Several health facilities have grappled with sanitizer theft, she said. "We try and place the dispensers in high-traffic areas only."

Michigan Wild Bird Surveillance (USDA, as of February 18): For the 2009 testing season (April 1, 2009-March 31, 2010), HPAI subtype H5N1 has not been recovered from any of the 111 Michigan samples tested to date, including 58 live wild birds, 39 hunter-killed birds and 14 morbidity/mortality specimens. H5N1 HPAI has not been recovered from 18,164 samples tested nationwide. For more information, visit the National HPAI Early Detection Data System at http://wildlifedisease.nbii.gov/ai/.

To learn about avian influenza surveillance in Michigan wild birds or to report dead waterfowl, go to Michigan's Emerging Disease website at http://www.michigan.gov/emergingdiseases.

Please contact Susan Peters at PetersS1@Michigan.gov with any questions regarding this newsletter or to be added to the weekly electronic mailing list.

Contributors

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Table 1. H5N1 Influenza in Poultry (Outbreaks up to February 13, 2010)

(Source: http://www.oie.int/downld/AVIAN%20INFLUENZA/A_AI-Asia.htm Downloaded 2/16/10)

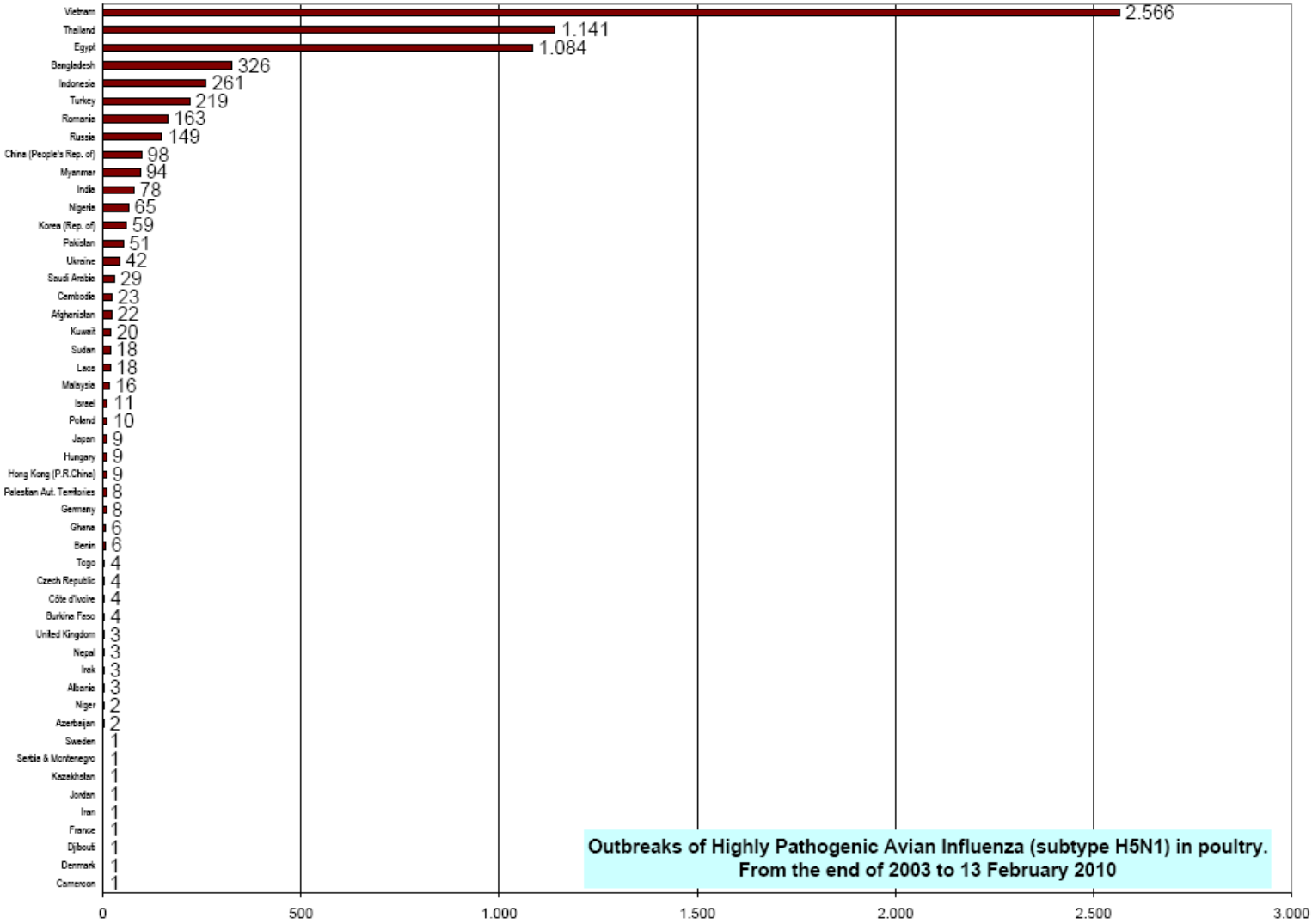

Table 2. H5N1 Influenza in Humans (Cases up to February 17, 2010)

(http://www.who.int/csr/disease/avian_influenza/country/cases_table_2010_02_17/en/index.html Downloaded 2/17/2010)

Cumulative number of lab-confirmed human cases reported to WHO. Total number of cases includes deaths.

Country	2003		2004		2005		2006		2007		2008		2009		2010		Total	
	cases	deaths	cases	deaths	cases	deaths	cases	deaths	cases	deaths	cases	deaths	cases	deaths	cases	deaths	cases	deaths
Azerbaijan	0	0	0	0	0	0	8	5	0	0	0	0	0	0	0	0	8	5
Bangladesh	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0
Cambodia	0	0	0	0	4	4	2	2	1	1	1	0	1	0	0	0	9	7
China	1	1	0	0	8	5	13	8	5	3	4	4	7	4	0	0	38	25
Djibouti	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0
Egypt	0	0	0	0	0	0	18	10	25	9	8	4	39	4	9	3	99	30
Indonesia	0	0	0	0	20	13	55	45	42	37	24	20	20	19	1	1	163	135
Iraq	0	0	0	0	0	0	3	2	0	0	0	0	0	0	0	0	3	2
Lao People's Democratic Republic	0	0	0	0	0	0	0	0	2	2	0	0	0	0	0	0	2	2
Myanmar	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0
Nigeria	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	1	1
Pakistan	0	0	0	0	0	0	0	0	3	1	0	0	0	0	0	0	3	1
Thailand	0	0	17	12	5	2	3	3	0	0	0	0	0	0	0	0	25	17
Turkey	0	0	0	0	0	0	12	4	0	0	0	0	0	0	0	0	12	4
Viet Nam	3	3	29	20	61	19	0	0	8	5	6	5	5	5	0	0	112	57
Total	4	4	46	32	98	43	115	79	88	59	44	33	72	32	10	4	478	286